| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | | (X3) DATE SURVEY | |
|--|------------------------|--------------------------------|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 01 | COMPLETED |
| | | 155095 | B. WING | | 01/27/2012 |
| NAME OF A | DD OLUBER OR GURRI IEI | | STREET | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF | PROVIDER OR SUPPLIEI | R | 2001 H | OBSON RD | |
| HERITA | GE PARK | | FORT | WAYNE, IN 46805 | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | NCY MUST BE PERCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| K0000 | | | | | |
| ĺ | A Life Safety C | ode Recertification | K0000 | The creation and submission of | |
| | and State Licer | nsure Survey was | | the Plan of Correction does no | |
| | conducted by | the Indiana State | | constitute an admission by this providerof any conclusion set | · |
| | Department of | | | forth in the statement of | |
| | 1 | th 42 CFR 483.70(a). | | deficiencies, or of any violation regulation. This provider | ı of |
| | Survey Date: (| 01/27/12 | | respectfully requests that the 2567 Plan of Correction be consideredthe Letter of Credib | nle |
| | Facility Numbe | er: 000038 | | Allegation.The facility requests | |
| | Provider Numb | | | post survey revisit on or before | e |
| | | | | 2/20/12 | |
| | AIM Number: | 100274830 | | | |
| | Surveyor: Amy | / Kelley, Life Safety | | | |
| | Code Specialis | t | | | |
| | | ety Code survey, | | | |
| | _ | was found not in | | | |
| | · | th Requirements for | | | |
| | Participation in | | | | |
| | Medicare/Med | • | | | |
| | Subpart 483.7 | 0(a), Life Safety | | | |
| | from Fire and | the 2000 edition of | | | |
| | the National Fi | re Protection | | | |
| | Association (N | FPA) 101, Life Safety | | | |
| | Code (LSC), Ch | apter 19, Existing | | | |
| | | ccupancies and 410 | | | |
| | IAC 16.2. | • | | | |
| | | e | | | |
| | This one story | | | | |
| | | be of Type V (111) | | | |
| | construction a | nd was fully | | | |
| | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 02/20/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: 155095 | A. BUILI B. WING | DING | <u>01</u> | COMPL 01/27/ | ETED |
|--------------------------|--|---------------------|--------------------|---|-----------------|----------------------------|
| | PROVIDER OR SUPPLIER GE PARK | | 2001 HC | DDRESS, CITY, STATE, ZIP CODE DBSON RD VAYNE, IN 46805 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | Р | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| | sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and only the resident rooms on the 200 hall. The remaining resident rooms do not have smoke detectors. The facility has a capacity of 180 and had a census of 172 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/31/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4Y9221

Facility ID: 000038

If continuation sheet Page 2 of 14

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE : | SURVEY |
|---------------|-------------------------------------|--|-----------------------------------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | DENTIFICATION NUMBER: A. BUILDING | | 01 | COMPL | ETED |
| | | 155095 | B. WIN | | | 01/27/ | 2012 |
| | | | D. 1111 | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | OBSON RD | | |
| HERITAG | GE PARK | | | | WAYNE, IN 46805 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | ↓ | TAG | DEFICIENCY) | | DATE |
| K0014 SS=E | including exposed buildings such as | orridors and exitways, interior surfaces of fixed or movable walls, s, and ceilings has a flame lass A or Class B. | | | | | |
| 1 | Based on obser | vation and | K00 |)14 | 1. No residents were found to | | 02/20/2012 |
| | interview, the f | acility failed to | | | affected by the alleged deficient practice. Areas have been treated after the affected by the alleged deficient affect | | |
| | provide docum | entation for the | | | to provide a flame spread ratin | | |
| | flame spread ra | ating of interior | | | of Class A or B2. All residents | - | |
| | finish materials | installed within | | | residing on 700, 800 and 900 | | |
| | exit access for | 3 of 9 corridors the | | | halls had the potential to be affected by the alleged deficien | nt | |
| | facility. This de | eficient practice | | | practice.3. We are no longer | 11 | |
| | could affect all | occupants in the | | | installing carpeting on walls. A | ۱s | |
| | 700, 800, and | | | | we remodel the building we wi | | |
| | Findings includ | e: | | | obtain appropriate flame sprearatings from our vendors for interior finish surfaces.4. Vendors will be required to provide flame spread rating | id | |
| | Based on obser | vations with the | | | information at the time the wor | k | |
| | Maintenance Su | upervisor on | | | begins, if unable to do so, the | | |
| | 01/27/12 duri | ing the tour from | | | Executive Director or designed | ; | |
| | 12:45 p.m. to 1 | 1:10 p.m., carpet | | | will not allow the work to continue. Executive | | |
| | was installed o | n the bottom one | | | Director/Designee will visualize | e | |
| | third of the cor | ridor walls in the | | | flame spread ratings where | - | |
| | 700, 800 and 9 | 000 halls. Based on | | | needed by regulation, before | | |
| | an interview wi | th the Maintenance | | | remodel work begins. A file of | , | |
| | Supervisor at th | ne time of | | | flame spread ratings will be maintained in the facility. The | | |
| | | o documentation | | | CQI team will review this file, | | |
| | · · | o demonstrate the | | | quaterly for compliance, | | |
| | | a flame spread | | | on-going. | | |
| | rating of Class | · | | | | | |
| | 39 5. 555 | | | | | | |
| | 3.1-19(b) | | | | | | |
| | | | | | | | |
| | | | 1 | | i . | | |

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Event ID: 4Y9221

Facility ID: 000038

If continuation sheet

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | — COMI | E SURVEY PLETED 7/2012 |
|--------------------------|---------------------------------|--|--|--|------------------------------------|------------------------------|
| NAME OF P | ROVIDER OR SUPPLIEF | | | ADDRESS, CITY, STATE, ZIP C OBSON RD | ODE | |
| HERITAG | SE PARK | | | WAYNE, IN 46805 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | RECTION HOULD BE APPROPRIATE | (X5) COMPLETION DATE |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4Y9221

Facility ID: 000038

If continuation sheet

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PRINTED: 02/20/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION IDENTIFICATION NUMBER: 155095 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED 01/27/2012 |
|--------------------------|---|--|--|--|
| | PROVIDER OR SUPPLIER GE PARK | 2001 H | ADDRESS, CITY, STATE, ZIP CODE OBSON RD WAYNE, IN 46805 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| K0018 SS=E | Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure the door protecting corridor opening for 1 of 1 Social Service offices was smoke resistive. This deficient practice could affect any resident near the Social Service door in the event of an emergency. Findings include: Based on an observation with the Maintenance Supervisor on 01/27/12 at 1:25 p.m., the corridor door to the Social Service office was a Dutch type door. There was an one half inch gap between the upper and lower halves of the door. Measurements were provided by the Maintenance | K0018 | 1. No residents were found to affected by the alleged deficie practice. Doors indicated in the survey have been replaced which solid doors to provide a smok resistant barrier. All resider in the area of the Social Servit office had the potential to be affected by the alleged deficie practice. No purchase order will be approved for the purch of "dutch" doors. A. Executive Director reviews all purchase orders prior to purchases being made. Purchase orders are a reviewed monthly by managers-on-going. | ent he hith he hits he |

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| | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155095 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | COM 01/2 | TE SURVEY PLETED 27/2012 |
|--------------------------|--|--|--|----------|----------------------------|
| HERITA | PROVIDER OR SUPPLIER GE PARK | 2001 H | ADDRESS, CITY, STATE, ZIP CO OBSON RD VAYNE, IN 46805 | ODE | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| | Supervisor at the time of observation. | | | | |
| | 3.1–19(b) | | | | |
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| | | | JLTIPLE CC | ONSTRUCTION | (X3) DATE | | |
|---------------|---|---|------------|-------------|--|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 01 | COMPL | |
| | | 155095 | B. WIN | | | 01/27/ | 2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HERITAG | GE PARK | | | | OBSON RD WAYNE, IN 46805 | | |
| (X4) ID | SUMMARY ST | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PERCEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | - | TAG | DEFICIENCY) | | DATE |
| K0029 SS=E | fire-rated doors) of fire extinguishing state and/or 19.3.5 areas. When the actinguishing syste areas are separate smoke resisting pare self-closing an protective plates the inches from the bopermitted. 19.3.5 Based on observinterview, the fact and latched into the kitchen, a hard provided with late and latched into this deficient pany resident in room. Findings includes Based on observinterview, the fact and latched into the company resident in room. Findings includes Based on observinterview, the fact and latched into the company resident in room. | evation and acility failed to 2 corridor doors to nazardous area, was atching hardware to the door frame. The door frame are actice could affect the main dining e: Evation with the approvisor on 2:35 p.m., the main as open to the et the requirements of allowed to be aridor. The wall aing room is dered to be the The door entering ar the pass through | K00 |)29 | 1. No residents were found to affected by the alleged deficie practice. The dietary door indicated in the survey has be replaced with a door with latch hardware and which latches in the door frame.2. Residents in the a area of the main dining roth had the potential to be affected this alleged deficient practice. Executive Director approves a purchase order prior to purchase being made.4. Executive Director approves all purchase orders propurchase being made. Purhase order are are reviewed monthly with managers, on-go | en eing to oom d by 3. II uses ctor ior | 02/20/2012 |
| | window lacked | latching hardware | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155095 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE | (X3) DATE SURVEY COMPLETED 01/27/2012 | |
|--|--------------------------------|---|---|--|----------------------|
| | PROVIDER OR SUPPLIE GE PARK | R | 2001 H | OBSON RD WAYNE, IN 46805 | |
| (X4) ID PREFIX TAG | SUMMARY S | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | frame. This w | cch into the door as confirmed by the upervisor at the ation. | | | |
| | 3.1-19(b) | | | | |
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Event ID: 4Y9221

Facility ID: 000038

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PRINTED: 02/20/2012 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CC | ONSTRUCTION O1 | (X3) DATE (COMPL | |
|-------------------|--|--|---------|--------------|---|---|------------------|
| AND PLAN | OF CORRECTION | 155095 | A. BUII | LDING | 01 | 01/27/ | |
| | | 100080 | B. WIN | | | 01/2// | 2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| HERITAC | SE PARK | | | | OBSON RD WAYNE, IN 46805 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING DISORMATION) | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION |
| TAG K0051 SS=F | A fire alarm system components, device installed according Alarm Code, to profire in any part of the complete fire a fire alarm initiation extinguishing system in patient sleeping provided that many 200 feet of nurse's located in the path written records of reliable second so Fire alarm systems accordance with Normaintenance are known that the system in the system in the system of the system in the system of the system | n with approved ces or equipment is to NFPA 72, National Fire ovide effective warning of the building. Activation of clarm system is by manual to automatic detection or the operation. Pull stations areas may be omitted the pull stations are within to stations. Pull stations are to of egress. Electronic or the stations. Pull stations are to of egress. Electronic or the stations are wailable. A turce of power is provided. The readily available. The power is provided. The power is provided. The power is provided. The power is provided. The provided to the provided to the alarm control to an area not to cupied, was that the power is provided. The power is provided. The provided to the provided to the provided to the provided at the the provided at the the provided in an | Koo | TAG | | be nt nere ts d by 3. . If es, ew | DATE 02/20/2012 |
| | • | | | | | | |

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| AND PLAN OF CORRECTI | | A. BUILDING B. WING | 01 | COMPLETED 01/27/2012 |
|--|--|----------------------|---|----------------------|
| NAME OF PROVIDER OR HERITAGE PARK | SUPPLIER | 2001 H | ADDRESS, CITY, STATE, ZIP CODE OBSON RD WAYNE, IN 46805 | |
| PREFIX (EACH | MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PERCEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| practice | ition. This deficient could affect all residents, d visitors in the facility. | | | |
| Findings | include: | | | |
| Maintena 01/27/1 alarm co was loca behind t electrica detector by the M | n observation with the ance Supervisor on 2 at 1:50 p.m., the fire entrol panel phone dialer ted in the electrical room he kitchen and was not lly supervised by a smoke. This was acknowledged aintenance Supervisor at of observation. | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|--|--|--|--------|--|-------------------------------------|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 01 | COMPL | ETED |
| | | 155095 | B. WIN | | | 01/27/ | 2012 |
| NAME OF F | ADOLUDED OD GUDDU IED | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 2001 H | OBSON RD | | |
| HERITAC | GE PARK | | | FORT V | VAYNE, IN 46805 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PERCEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF | | ΓE | COMPLETION | |
| | | <u> </u> | <u> </u> | IAG | DEFICIENCE | | DATE |
| K0056 SS=F | If there is an autor installed in accord Standard for the Ir Systems, to provice all portions of the properly maintaine NFPA 25, Standar Testing, and Mainterstring, and Mainterstring and Mainterstring and Mainterstring and tamper states are supply for the sprinkler systems flow and tamper states alarm system. 1. Based on obtainer accordance with Sprinkler systems accordance with Standard for the Sprinkler System complete cover of the building practice could accordance with Sprinkler Systems accordance with Spr | e is a reliable, adequate ne system. Required are equipped with water witches, which are cted to the building fire 19.3.5 Deservation and facility failed to blete automatic m was provided for r riser rooms in h NFPA 13, ne Installation of ms, to provide rage for all portions . This deficient affect all occupants. de: Deservation with the upervisor on 1:00 a.m., the room lacked | K00 | TAG | 1. No residents were found to affected by the alleged deficient practice. Sprinkler has been installed in the sprinkler riser room. Sprinkler head in dietar has been relocated to meet the standard. Sprinkler head has been installed under the canopidentified in the deficiency. 2. A residents in the areas identified had the potential to be affected the alleged deficient practice. 3 These alleged issues had never been identified in any prior life safety survey. The Executive Director will assure there are recoccurences by review of any physical plant changes related sprinklers. 4. Executive Director will review as indicated in #3. CQI will review any physcial plant changes related to sprinklers prior to implementation, on-going the safety of the safet | y e e by All d by s. eer to or dant | DATE 02/20/2012 |
| | Supervisor at th | | | | | | |

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Event ID: 4Y9221

Facility ID: 000038

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| | TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155095 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE SURVEY COMPLETED 01/27/2012 |
|--------------------------|--|--|--|---------------------------------------|
| | PROVIDER OR SUPPLIER GE PARK | 2001 H | ADDRESS, CITY, STATE, ZIP CODE OBSON RD VAYNE, IN 46805 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | (X5) COMPLETION DATE |
| | observation. | | | |
| | 3.1-19(b) | | | |
| | 2. Based on observation and interview, the facility failed to ensure 2 of 9 sprinkler heads in the kitchen dish room were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5–6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect all kitchen staff and any resident in the main dining room. Findings include: Based on an observation with the Maintenance Supervisor on 01/27/12 at 12:30 p.m., two sprinkler heads near the dish machine in the kitchen dish room were mounted sixty three inches apart. Measurements were provided by the Maintenance Supervisor at the time of | | | |
| | observation. | | | |
| | 3.1–19(b) | | | |
| | 3. Based on observation and | | | |

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| | of Correction identification number: 155095 | A. BUILDING B. WING | | COMPLETED 01/27/2012 | | |
|--------------------------|---|---|---|----------------------|--|--|
| | PROVIDER OR SUPPLIER GE PARK | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | | |
| | interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 4 building canopies in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13–1999 Edition, Section 5–13.8.1 requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect any resident evacuated through the Rehabilitation entrance # 3 in the event of an emergency. Findings include: Based on an observation with the Maintenance Supervisor on 01/27/12 at 1:05 p.m., the Rehabilitation entrance # 3 had an unsprinklered combustible overhang made of wood frame construction extending fifty six inches from the building. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1–19(b) | | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE SURVEY COMPLETED 01/27/2012 | | | | |
|---|------------------------------------|---|--|---|---------------------------------------|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD | | | | | | | | | |
| HERITAC | HERITAGE PARK FORT WAYNE, IN 46805 | | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4Y9221

Facility ID: 000038

If continuation sheet

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